SPORTS MEDICINE PATIENT INFORMATION

If you are unsure of a question or do not feel well enough to complete this form you may leave it blank and ask for assistance from the medical assistant when you are called back. Thank you.

Name: ____________________ **Today's Date:** ____________

D.O.B.: ________ **Age:** _____ **Gender:** ________ **Sport:** __________ **School:** ____________

Primary Reason(s) for Today's Visit: **Date of Injury:** ____________________

____

How were you referred to our center?: ____________________________

Are you experiencing any of the following symptoms?: ❑ No

❑ Chills	❑ Numbness	❑ Muscle Pain
❑ Fatigue	❑ Anxiety	❑ Muscle Weakness
❑ Fever	❑ Depression	❑ Neck Weakness
❑ Nausea	❑ Laceration / Abrasion	❑ Neck Pain
❑ Vomiting	❑ Back Pain	❑ Bruising
❑ Dizziness	❑ Joint Pain	
❑ Headache	❑ Joint Swelling	

Allergies: (Drug or Non Drug Related) ❑ Unknown ❑ See List

1. ____________________ Reaction: ____________________
2. ____________________ Reaction: ____________________
3. ____________________ Reaction: ____________________
4. ____________________ Reaction: ____________________

Current Medications (Including Birth Control Pills, Vitamins, Supplements, and Inhalers): ❑ None

1. ____________________ Dosage: __________ Frequency: __________
2. ____________________ Dosage: __________ Frequency: __________
3. ____________________ Dosage: __________ Frequency: __________
4. ____________________ Dosage: __________ Frequency: __________

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Chronic Illness: ❑ None (Please include the year diagnosed)

❑ Anemia _____
❑ Atrial Fibrillation _____
❑ Arthritis _____
❑ Asthma _____
❑ Anxiety _____
❑ Blood Clots _____
❑ Cancer _____
❑ COPD _____
❑ Depression _____
❑ Diabetes _____
❑ High Blood Pressure _____
❑ Hepatitis A, B, C _____
❑ Heart Attack _____
❑ Insomnia _____
❑ Migraines _____
❑ Osteoporosis _____
❑ Seasonal Allergies _____
❑ Seizures _____
❑ Thyroid Disease _____

Surgical History: ❑ None ❑ See List

1. ______________________________ Year: ____________
2. ______________________________ Year: ____________
3. ______________________________ Year: ____________

Family History: Has anyone in your **immediate** family been diagnosed with any of the following? ❑ No
(Please include family relation)

❑ ADD / ADHD / Dyslexia __________
❑ Anemia __________
❑ Arthritis __________
❑ Asthma __________
❑ Anxiety __________
❑ Atrial Fibrillation __________
❑ Blood Clots __________
❑ Cancer __________
❑ COPD __________
❑ Depression __________
❑ Diabetes __________
❑ Heart Attack __________
❑ Hepatitis A, B, C __________
❑ High Blood Pressure __________
❑ Insomnia __________
❑ Migraines __________
❑ Osteoporosis __________
❑ Seasonal Allergies __________
❑ Seizures __________
❑ Thyroid Disease __________
❑ Alzheimer's Disease __________

Social History:

Marital Status: ❑ Married ❑ Single ❑ Divorced Occupation: ____________ ❑ Retired ❑ Student __________

Do you Exercise? ❑ No ❑ Yes, please list type and frequency: ______________________________

Do you smoke and/or use tobacco? ❑ No ❑ Former ❑ Yes, type: ______________________________

Do you drink alcohol? ❑ No ❑ Former ❑ Yes, amount: ______________________________

Do you consume caffeine? ❑ No ❑ Yes, please list type and quantity: ______________________________

Do you use any illicit drugs? ❑ No ❑ Yes, please list type and quantity: ______________________________

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